Department of Health and Welfare
BUREAU OF FACILITY STANDARDS
Residential Community Care Program
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-6626
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2006 ANNUAL REPORT AND APPLICATION FOR RENEWAL OF RESIDENTIAL CARE/ASSISTED LIVING FACILITY LICENSE

I. FACILITY INFORMATION

a. Facility Name:	
b. Facility Physical Address:	c. Facility Mailing Address:
d. Facility Telephone Number:	e. Facility Fax Number:
f. E-mail address	g. Licensed Bed Capacity:

II. ADMINISTRATOR INFORMATION

a. Administrator's Name:	b. Residential Care Administrator License Number:
c. Other Residential Care/Assisted Living Facilities for which the administrator has responsibility:	

III. RESIDENT SERVICES

Types of Service. Check all service types offered by the facility.

☐ DEMENTIA ☐ DEVELOPMENTAL DISABILITY ☐ ELDERLY

☐ MENTAL ILLNESS ☐ TRAUMATIC BRAIN INJURY

IV. RESIDENT CENSUS AS OF SEPTEMBER 30, 2006

SERVICE TYPE (PRIMARY DIAGNOSIS)	# OF RESIDENTS
Dementia	a.
Developmental Disability	b.
Elderly	c.
Mental Illness	d.
Traumatic Brain Injury	e.
TOTAL	f.

PAYOR SOURCE	# OF RESIDENTS
Private Pay	g.
Medicaid	h.
Other	i.
TOTAL	j.

NOTE: Please place each resident into one (1) category for Service Type and one (1) category for Payor Source. The totals in fields "f" and "j" should match.

V. FACILITY STAFFING INFORMATION FOR THE WEEK OF SEPTEMBER 25, 2006

JOB DESCRIPTION	# OF FTEs
Administration	a.
Direct Care	b.
Other	c.
TOTAL	d.

NOTE: A full-time equivalent (FTE) is the number of man-hours assigned to that position in a week divided by 40. For example, two part-time direct care workers at 20 hours per week would equal one (1) Direct Care FTE (20 + 20 / 40 = 1). FTEs are calculated by the number of hours worked by staff, not by the number of staff members.

VI. OWNERSHIP INFORMATION

a. Owner Name:	b. E-mail address:
c. Owner Mailing Address:	d. Owner Telephone Number:
	e. Owner Fax Number:
f. Contact Name:	

g. Disclosure of Ownership. Identify all persons or business entities holding an interest of 10% or more in the facility as a business. If the owner is a business, please give the full legal name of the entity:

NAME	%

Please attach a separate sheet if this space is not adequate.

VII. REPORT/APPLICATION VERIFICATION

BY SIGNING BELOW, I ACCEPT AND ACKNOWLEDGE THE FOLLOWING:

1) **I am authorized to represent the facility.**

2) **I have named all owners having an interest in the facility of 10% or more, and I represent their interests on behalf of the facility.**

3) **I understand that the license is non-transferable, nor can it be assigned to another.**

4) **I am responsible for maintaining the facility's compliance with the applicable laws and rules.**

5) **Should I terminate my relationship with the facility, or if the facility changes ownership or control, I will immediately notify the Bureau of Facility Standards of the change.**

6) **I certify that the statements made in this report are true, complete, and correct to the best of my knowledge.**

Printed or Typed Name _____ Title _____

Signature _____ Date _____